LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

PRIORITIES AND PLANNING (P&P) COMMITTEE MEETING MINUTES

November 29, 2011

MEMBERS PRESENT	MEMBERS ABSENT	PUBLIC	COMM STAFF/ CONSULTANTS
Al Ballesteros, *Co-Chair*	Abad Lopez	Luke Klipp	Jane Nachazel
Bradley Land, *Co-Chair*		Scott Singer	Craig Vincent-Jones
Douglas Frye		Jason Wise	
David Kelly			
Ted Liso			
Anna Long		**DHSP STAFF**	
Quentin O'Brien		Rhodri Dierst-Davies	
Carlos Vega-Matos		Amy Wohl	
Tonya Washington-Hendricks		Dave Young	

CONTENTS OF COMMITTEE PACKET

1) **Agenda**: Priorities and Planning (P&P) Committee Meeting Agenda, *11/29/2011*
2) **Minutes**: Priorities and Planning (P&P) Committee Meeting Minutes, *10/25/2011*
3) **PowerPoint**: 2011 Los Angeles County Coordinated HIV Needs Assessment (LACHNA-Care), *11/29/2011*
4) **Table**: FY 2011 Part A & MAI Allocations Table, *2011*
5) **Table**: FY 2012 Ryan White Part A/Part B SAM Care Allocations/Expenditures, *11/29/2011*
6) **Table**: Fiscal Year 2010 Ryan White Part A and B Allocations, *8/11/2009*
7) **Minutes**: Commission on HIV Meeting Minutes, *12/9/2010*
8) **Minutes**: Commission on HIV Meeting Minutes, *3/10/2011*
9) **Policy/Procedure**: Priority- and Allocation-Setting Framework and Process, *5/12/2011*
10) **Table**: Priority- and Allocation-Setting Timeline, *ongoing*
11) **Chart**: Priority- and Allocation-Setting (P-and-A) Process Timeline, *5/12/2011*
12) **Table**: Priority- and Allocation-Setting Timeline, *5/12/2011*
13) **Table**: Fiscal Year 20XX Priority- and Allocation-Setting Change Matrix, *5/12/2011*
14) **Article**: New Law on Telehealth May Mean Better Care, Easy Access, *11/28/2011*
15) **PowerPoint**: Innovations in Health Care: How to Impact Access, Quality and Cost, *2011*
16) **Legislation**: AB 415: Healing arts: teleheath, *10/7/2011*
17) **Memorandum**: Tele-Health Services, *2/7/2011*
18) **Work Plan**: Los Angeles County Commission on HIV, IV. Priorities and Planning (P and P) Committee, FY 2011 Work Plan
19) **Memorandum**: FY 2012 Contingency Funding Scenario Directives, *8/29/2011*
20) **Memorandum**: SPA 1 Priorities and Allocation Plan, *5/1/2009*

1. **CALL TO ORDER**: Mr. Ballesteros called the meeting to order at 1:50 pm and attendees stated their conflicts-of-interest.

2. **APPROVAL OF AGENDA**:
   MOTION #1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION #2: Approve the 10/25/2011 Priorities and Planning (P&P) Committee Meeting Minutes **(*Passed by Consensus*)**.

4. **PUBLIC COMMENT, NON-AGENDIZED**: There were no comments.

5. **COMMISSION COMMENT, NON-AGENDIZED**: There were no comments.

6. **CO-CHAIRS' REPORT**:
   A. **December Meeting Date Change**: The Committee areed to cancel the December meeting.

7. **2010-2011 LOS ANGELES COUNTY COORDINATED HIV NEEDS ASSESSMENT (LACHNA)**:
   - Dr. Wohl noted HRSA requires a needs assessment of a representative sample of Ryan White clients. The needs assessment, Los Angeles County Coordinated HIV Needs Assessment (LACHNA), assesses awareness and need for services, services received, barriers to services needed but not received, and satisfaction with services.
   - A needs assessment assesses if existing HIV services are sufficient, helps prioritize relative importance of HIV service categories across regions and populations, and helps prioritize and guide funding when a range of options for HIV services is available.
   - The stratified probability-based proportional-to-size methodology was developed in consultation with a UCLA statistician and the CDC. Sampling was in two stages: Level 1, site, 46 of 100 sampled; Level 2, patient, 450 of 18,000 sampled.
   - Power calculations indicated 400 patients were sufficient for a representative sample of the 18,000 patients (2009 data), but 50 were added to over-sample underrepresented populations of youth, transgenders, and IDUs. Sites were stratified into medical, social services, residential, oral health, and substance abuse to ensure a representative sample.
   - Mr. Singer noted the last LACHNA targeted home-based case management clients who typically do not access services at sites. Results identified a gap. Mr. Vincent-Jones replied resources were more limited for this LACHNA prompting reductions in the assessment capacity, e.g., the 2009 LACHNA sampled 700 clients and more special populations. It is assumed clients in the system will use at least one service. Related to hospice services, there were six clients over three years. Often residential care clients prefer to remain in those facilities.
   - Real-time sampling was used to select participants with a grid of days/times/services that were available per site. Recruitment day/times were randomly selected with clients approached on arrival. Interval of clients approached was based on the size of the site. The response rate for those approached was 94%. Limited data was collected from non-respondents.
   - Eligible participants were: 18 or older, HIV+, willing to provide written consent in English or Spanish, Los Angeles County residents, and a client of a Ryan White-funded provider. Six IRB approvals were required to collect the information.
   - Surveys took about 45 minutes. They were self-administered in English or Spanish on laptops, with technical assistance available if needed and such assistance tracked. Surveys were confidential with no names attached. Names are on consent forms are kept separately. Names can be linked to surveys, but such information is kept in secured files.
   - Surveys were completed in January to June 2011 with $30 in Ralphs or Target cards per participant for compensation.
   - Survey sections were: Demographics; HIV Testing and Medical Care History; Service Utilization with Awareness, Need, Utilization, Barriers, Satisfaction; Overall Health Status, including mental health; Sexual Behavior; Substance Use; Oral Health.
   - There were questions on 47 services in clusters for: Health-Related, Case Management, Housing/Transportation, and Support. Clusters were used for convenience with a balance of clients per cluster. Each service category was clearly defined.
   - There were three analyses of data. In the first analysis, descriptive data was presented by service clusters and for individual services. Individual services were presented by the top 10 services participants were aware of, expressed a need for, and received, and noted gaps, as well as services participants were least aware of and for which they expressed the least need.
   - The second analysis comprised barriers that were analyzed: "Structural," e.g., too much paperwork/red tape or too many rules/regulations; "Organizational," e.g., provider insensitivity, length of waiting time, wrong referrals provided; and "Individual," e.g., not aware service/ treatment available, not aware of service location, did not know who to ask for help.
   - The third analysis constituted logistic regression used to predict factors associated with service need gaps for the total study sample, individual service clusters, and specifically for oral health. Variables selected were based on significant results from bivariate analysis.

- Comparison of LACHNA participant and Ryan White demographics shows strong correlation with oversampling per design for youth and transgenders. Some Ryan White columns are blank as Casewatch data was not available.
- Nearly two-thirds of LACHNA participants were gay/lesbian/bisexual. The majority of LACHNA participants (56%) and Casewatch (61%) had no insurance. Casewatch only reflects currently homeless (6.2%) while LACHNA reflects both currently homeless (12%) and chronically homeless (12%), which may overlap.
- Most (99.1%) were aware of Ryan White-funded services overall. Awareness by cluster was: Health-Related, 98.4%; Case Management, 92.0%; Support, 90.4%; Housing, 80.4%; and Transportation, 78.7%. Awareness of individual services ranged from 89.1% for medical outpatient to 19.1% for hospice. Respondents were aware of an average 21.3 services of the 47.
- Respondents were asked if they knew a service was available to Ryan White clients. Those who were not aware may have had private insurance or were unaware of a service's funding. Those who expressed a service need received a referral.
- Most (99.7%) expressed need for Ryan White-funded services overall. Need by cluster was: Health-Related, 99.6%; Case Management, 86.0%; Support, 84.0%; Transportation, 75.6%; and Housing, 64.9%. Need for individual services ranged from 93.8% for medical outpatient to 1.8% for child care. Respondents expressed need for an average 11.6 services of the 47.
- Most (98.9%) received some Ryan White-funded services. Receipt by cluster was: Health-Related, 98.4%; Case Management, 76.4%; Support, 67.6%; Transportation, 58.9%; and Housing, 37.8%. Overall satisfaction (88.6%) and access (89.4%) were high. Those receiving an individual service ranged from 90.2% for medical outpatient to 0.9% for hospice. Respondents received an average 7.5 services of the 47 with high satisfaction (88.6%) and access (89.4%) rates.
- Mr. Vega-Matos noted a client may perceive a need and may be eligible for or receive services in a continuum of care not funded by Ryan White. Mr. Vincent-Jones stressed LACHNA's purpose was to evaluate system effectiveness. Mr. O'Brien noted his agency provides non-Ryan White-funded case management, so he felt the "service gap" is unclear.
- Most (80.6%) reported some Ryan White-funded service gap. Gaps per cluster were: Housing, 64.4%; Support, 60.6%; Health-Related, 59.8%; Transportation, 35.0%; and Case Management, 29.2%. Overall, barriers were relatively equal among Structural, 35.1%; Organizational, 26.6%; and Individual, 35.1%, but cluster and single service gaps were primarily Individual. The highest reported service gap was 34.2% for oral health. The average number of reported gaps was 3.9 of 30 services.
- Mr. Vincent-Jones asked if there were oral health responses that might indicate stigma, but Dr. Wohl said there were not.
- Logistic regression was used to predict differences in service gaps, i.e., those reporting gaps versus those who did not. Overall, there were no differences in reporting a service gap by demographic variables. Separate analyses within racial/ethnic groups were similar except that lower socioeconomic Latinos were three times as likely to report a service gap.
- Dr. Wohl noted medical history was self-reported. Less than 20 respondents reported fewer than two visits per year. While the methodology is not the best to identify those out of medical care (unmet need), more had been anticipated.
- On Health-Related service gap predictors: after controlling for incarceration, insurance, Federal Poverty Guidelines (FPG), citizenship, travel time, employment, race/ethnicity, age, homelessness, MSM status: individuals who reported recent (last six months) substance use were almost twice as likely to report gaps in Health-Related services. Substances included heroin, cocaine, stimulants, amphetamine and binge drinking (four or more drinks in one sitting for a man or three for a woman).
- On Housing service gap predictors: after controlling for incarceration, gender, citizenship, mental illness, employment, and return to care status after at least a year break in care: those uninsured, at or below FPG, infected with HIV five years or less, and the currently homeless were significantly more likely to have a gap in Housing services.
- On Transportation gap predictors: after controlling for insurance status, FPG, citizenship, MSM status, education, lapse in care, and time since infection: those recently incarcerated and interviewed in Spanish were much more likely to have a gap.
- On Case Management gap predictors: after controlling for incarceration status, insurance status, travel time to doctor, race/ethnicity, citizenship, MSM status, marital status, sexual orientation: 25-49 year-olds were more likely to have a gap.
- On Support service gap predictors: after controlling for incarceration status, homelessness, recent mental illness, substance use, and a lapse in care: uninsured persons and those at or below FPG were more likely to have a gap in Support services while those infected with HIV for less than or equal to five years were significantly less likely to have such a gap.
- On conclusions, overall Ryan White-funded service awareness was high. Categories with high awareness included: Health-Related, Case Management by a social worker, Housing, Transportation, and Support that included groceries or food.
- On need, all respondents reported a need for at least one service category. Need was highest for Health-Related services (99.6%) followed by need for Case Management (86.0%), Support (84.0%), Transportation (75.6%), and Housing (64.9%).
- On satisfaction, overall satisfaction with received services was high with about 90%, reporting satisfaction and only 10% reporting some dissatisfaction. Few problems were reported accessing needed services (11%).

- On gaps, at least one service need was common among respondents (80.6%) with few trends by demographic characteristics or behaviors. Service clusters with the largest gaps were Housing (64.4%) and Support (60.6%), but the single service category with the largest gap for all respondents and most subpopulations was oral health (34.2%).
- The most common barrier to needed services was lack of information on availability, location, or who to ask for help.
- Due to the sampling methodology and high response rate (94%) data from this sample of clients in the County's Ryan White-funded system is generalizable to all system clients. Data can be used to guide policy decisions on the system.
- Mr. Vincent-Jones noted a challenge in generalizing to the entire system as respondents were accessed through it so those not regularly accessing the system would not have been reached in numbers. That affects barrier data in particular.
- Mr. Kelly asked about the definition of "lower income" especially as it relates to Latinos. Mr. Dierst-Davies noted FPG is calculated per income and number of dependents and is adjusted based on values for each metropolitan area. Mr. Vega-Matos added data compares low-income respondents of various race/ethnicities and reflects that Latinos have more challenges accessing services which is an important finding. He would also be interested in monolingual Spanish challenges.

➲ Change references to "agencies" to "sites."
➲ Mr. Vincent-Jones will review any identified gaps for home-based case management in the prior LACHNA.
➲ Dr. Wohl, Mr. Dierst-Davies and Mr. Vincent-Jones will develop language to clarify that data reported on some services may pertain to non-Ryan White-funded services in the continuum of care.
➲ Dr. Wohl will obtain nutrition support Structural and Organizational gap numerical data for Ms. Washington-Hendricks.
➲ Agreed to add the n value to slides, but not weight them as that leads to confusion in presentation.
➲ Add a slide on confidence intervals.
➲ Add "cluster" to predictor slides, e.g., "Health-Related Cluster."
➲ Change "citizenship" to "legal resident."
➲ Correct "OR=0.2" to "OR=2.0" for uninsured persons on "Predictors of Support Services Gaps" slide and check other slides.
➲ Add slide on limitations of study, e.g., respondents were all accessed through system sites.
➲ Incorporate both cluster and individual service category findings in conclusion slides.

8. FY 2011 PRIORITY- AND ALLOCATION-SETTING (P-AND-A):

A. Underspending:

- Mr. Young reported the Ryan White Part A grant award is $36.8 million with $36.6 projected spending for $233,539 in underspending. Projections are based on year-to-date invoices, trends for agencies with significant year-end costs, and DHSP program managers' input.
- Medical outpatient, including medical specialty and the Therapeutic Monitoring Program (TMP), is projected to spend $542,893 more than the allocation. Contracts are available to support spending. Mr. Vega-Matos noted that includes the shift on 7/1/2011, noted at an earlier meeting, of Hubert Humphrey Clinic services previously classified as Early Intervention Services (EIS) to medical outpatient to better reflect services offered.
- Benefits specialty reflects $275,562 in underspending due to a slow start-up, but invoices are increasing.
- Oral health care reflects overspending $227,348 compared to the allocation.
- Mental health, psychotherapy reflects underspending of $131,676, compared to allocation mostly from staff vacancies.
- Mental health, psychiatry reflects small overspending of $41,178 to some extent due to the Commission lowering its allocation. The landscape will be changing since Healthy Way LA will provide coverage for this service.
- Case management, medical reflects overspending of $170,079. Psychosocial is reflected under SAM Care/Part B.
- Health Insurance Premiums/Cost-Sharing (HIP/C-S) reflects savings of $393,631 as the RFP was pulled back twice to address changes in Health Care Reform and OA-HIPP. Contracts were deployed in January and start-up work has begun.
- Substance abuse, residential reflects underspending of $482,228. One provider closed last year, but DHSP is working with providers to increase outreach. It will also bring plans to reconfigure substance abuse to the Commission later.
- Medical transportation reflects savings of $129, 924 due to improved efficiency, e.g., clients previously accessed services at multiple agency sites, but now agencies receive one amount to distribute and track client use across sites. Eligibility now requires a client to be at 133% or less of the Federal Poverty Level (FPL).Taxi vouchers are tracked more closely and TAP cards replaced bus passes this year. Assistance was provided in the transition to TAP.
- Nutrition support reflects overspending of $197,984, but is spending up to the amount of existing contracts.
- The SAM Care/Part B grant award is $8.8 million with $7.5 million projected spending for $1,365,005 in underspending. Mr. Young noted this grant runs through June 2012 and estimates are based on only the first three months of invoices. Services with multiple funding streams such as substance abuse can shift expenditures to maximize grants.

- Case management, psychosocial reflects underspending of $119,189 compared to the allocation.
- EIS reflects significant underspending of $587,262. Charles Drew is the sole provider after the shift of $600,000 in Hubert Humphrey Clinic services to medical outpatient and Prototypes dropped its contract. Current services are no longer responsive to needs, but the Standards of Care (SOC) Committee is scheduling an Expert Review Panel on Testing and Linkage to Care Plus (TLC+) which will integrate EIS and inform a DHSP revamp of services.
- Substance abuse, residential is dual-funded. Under SAM Care/Part B expenditures reflect $233,369 in underspending.
- Case management, transitional reflects overspending of $122,992 in spending up to the amount of existing contracts.
- Hospice/skilled nursing facility has no expenditures resulting in savings of $590,446. There is currently no contracted provider for the service. Mr. Vega-Matos reported DHSP is working with the Commission to develop solutions starting with identifying the need. It is hard to contract solely for HIV. DHSP is exploring an option for a lower level of services that will be ready by March.
- Case management, home-based reflects a small overspending of $42,269 compared to the allocation.
- Mr. Vincent-Jones noted the $233,539 Part A overall underspending is relatively small, but needed to be addressed by February. SAM Care/Part B underspending is more significant at $1,365,005, but the grant would not close until June. In addition to re-allocations, P&P needed to choose how to address expenditure/allocation inconsistencies.
- One consideration regarding inconsistencies is alignment with YR 22 allocations. Changes made for YR 22 are: HIP/C-S, down 1%; case management, home-based, up 1%; mental health, psychiatry, up 0.1%; medical nutrition therapy, up 0.1% (though that is not a funded service category at this time); medical care coordination, up 0.5%; treatment adherence, classified by the Commission under medical outpatient, up 1.0%; substance abuse, residential, down 1.3%. Expenditures are trending in this direction.
- Mr. O'Brien felt the overall variance was small enough to be considered a margin of error. Key significant variances to him were underspending in benefits specialty and HIP/C-S, which are ramping up and will be combined going forward, and overspending in case management, medical, increased for YR 22 and contracted.
- Several noted organizations often allow line item variances of 10% without specific approval, as do most Federal grants. Mr. Vega-Matos added contingency planning rules still apply and DHSP brings any notable change to the Commission.
- Mr. Vega-Matos reported the Minority AIDS Initiative (MAI) roll-over budget request is due to HRSA 1/3/2012.
- Mr. Young reported MAI has a $3.8 million allocation which includes $674,000 of roll-over from the two previous MAI terms which must be spent by 2/28/2012. A roll-over of $936,903 is projected by the end of YR 21.
- Mr. Vincent-Jones noted the Commission approved a roll-over into oral health care last year. Mr. Vega-Matos said DHSP has completed an expansion plan. Some agencies took longer to submit paperwork, but it was submitted and is moving through the Board. Another County agency changed augmentation language so they cannot be included in the current phase of the expansion, but can only move forward on the day of Board approval for a temporary implementation delay. $1.5 million in additional oral health care funding is already in the pipeline.

➲ On underspending: address Part A and Minority AIDS Initiative (MAI); defer SAM Care/Part B deliberations to January.

MOTION #3 (*Ballesteros/Land*): Adjust expenditures to the full FY 21 estimate **(*Passed: Ayes,*** Ballesteros, Frye, Kelly, Land, Liso, O'Brien, Vega-Matos, Washington-Hendricks; ***Opposed,*** None; ***Abstentions,*** None**)**.

MOTION #4 (*O'Brien/Washington-Hendricks*): Authorize DHSP to increase expenditures up to $250,000 in any currently allocated category in order to fully expend the YR 21 Ryan White Part A grant **(*Passed: Ayes,*** Ballesteros, Frye, Kelly, Land, Liso, Long, O'Brien, Vega-Matos, Washington-Hendricks; ***Opposed,*** None; ***Abstentions,*** None**)**.

MOTION #5 (*O'Brien/Land*): Authorize DHSP to adjust allocations in the last half of the grant year up to 10% within each category in order to maximize grant expenditures **(*Passed: Ayes,*** Ballesteros, Frye, Kelly, Land, Liso, O'Brien, Vega-Matos, Washington-Hendricks; ***Opposed,*** None; ***Abstentions,*** None**)**.

MOTION #6 (*Land/Liso*): Approve Minority AIDS Initiative (MAI) roll-over amount to Oral Health Care as allocated in previous years **(*Passed: Ayes,*** Ballesteros, Frye, Kelly, Land, Liso, O'Brien, Vega-Matos, Washington-Hendricks; ***Opposed,*** None; ***Abstentions,*** None**)**.

9. **FY 2013 PRIORITY- AND ALLOCATION-SETTING (P-AND-A)**: This item was postponed.

10. **RESOURCE ANALYSIS SUBCOMMITTEE**: This item was postponed.

11. **TELEMEDICINE**: Mr. Vincent-Jones said he will attempt to arrange a presentation from LA Care to P&P on their eConsult program in January or February, in response to the prior year's directive to review telehealth/telemedicine efforts. Packet information for review includes an eConsult PowerPoint, California legislation passed last year and a memorandum on current Department of Health Services plans so that P&P can prepare to address the Commission directive to explore telehealth.

12. **ONGOING ACTIVITIES REPORT**: This item was postponed.

13. **NEXT STEPS**: This item was postponed.

14. **ANNOUNCEMENTS**: There were no announcements.

15. **ADJOURNMENT**: The meeting adjourned at 4:45 pm.